The Journal of Mental Science.

(1902. Vol. 48, No. 202, July.)

1. Report of Tuberculosis Committee of the Medico-Psychological Association of Great Britain and Ireland.
2. Toxemia in the Etiology of Mental Disease. Discussion by T. S. CLOUSTON and others.
3. Surgical Treatment of Delusional Insanity based upon its Physiological Study. T. CLAYE SHAW.
4. Sleep in Relation to Narcotics in the Treatment of Mental Disease. HENRY RAYNER.
5. Notes in Some Cases of Morphinomania. ROBERT JONES.
6. Evolution of Delusions in Some Cases of Melancholia. LIONEL WETHERLY.
7. Pupillary Symptoms in the Insane and their Import. T. P. COWEN.
8. Prophylaxis and Treatment of Asylum Dysentery. N. H. MACMILLAN.
9. The Psychiatric Wards in the Copenhagen Hospital. KNUD. PONTOPPIDON.
10. Clinical Notes and Cases.

1. *Tuberculosis Among the Insane.*—This subject has been widely discussed by the English alienists and the Report of the Medico-Psychological Association is given here in full. The work is mainly that of Dr. Eric France, who was appointed honorary secretary to the committee. The dangers are very fully pointed out and a most careful and comprehensive series of statistical tables emphasizes the great importance of the inquiry. Space permits only a short summary of this report. The conclusions given are: that phthisis is prevalent in the public asylums to an extent which calls for urgent measures. A very large number of cases of phthisis have acquired that disease after admission to the asylum. The special causes for this increased prevalence of phthisis in the asylums are: Overcrowding, with consequent insufficient day, and especially night, cubic space per patient; insufficiency of hours in the open air; defects in ventilation and heating; uncleanly habits and faults in dietary.

The *means of prevention* suggested are: Early diagnosis, isolation of all phthisical cases, limiting the size of future asylums, checking overcrowding, increasing day and night cubic space, restricting number of beds in dormitories, increased and more thorough natural ventilation per patient, stopping of promiscuous spitting, supervision of dietary, properly constructed hospitals and sanitoria, or these failing, temporary isolation hospitals or special wards and airing courts set aside for the purpose.

2. *Toxemia in the Etiology of Mental Disease.*—This is an interesting discussion of the etiological doctrine of toxemia in mental disease. Pathological workers are considered to hold more to the auto-intoxication theory than clinical observers. Dr. Clouston in opening the discussion suggests a number of queries which must be satisfactorily answered if the causative factors are to be found. The influence of mental factors is one of the first: consciousness and mental states are modified in sleep, the hypnotic state, etc., why may not exaggerations in these physiological processes be concerned in the insanities? The abrupt onset and equally sudden termination of many insanities seem inconsistent with known toxic activities: the specific reactivity of cortical cells to purely sensory stimuli exhibits very wide variations. Morbid activity or abnormal torpor might bring about such insane reactions and the

theory of toxemia is unnecessary. Ancestral hereditary reactivity is pointed out as one of the most potent factors in determining abnormal mental life, especially when faulty heredity renders a nervous system peculiarly susceptible, even to the slightest stimuli; developmental and involutional insanities, such as are seen at puberty and in senility surely do not need a toxic hypothesis; many brains, by a natural development of their original characters, determine a later mental disease; immunity correlatives should be borne in mind; elevations in temperature are not necessarily the reaction to a bacterial or toxic agent. Toxemia might be an element in many insanities, 'tis true, but is it not more scientific to regard it as a secondary activity, rather than a primary one? The medical psychologist holds that the cerebral cortex is the real controlling center of secretory and excretory processes and of nutrition, and in its action or inaction might cause or counteract those states of non-resistiveness through which injurious bacteria and toxins were developed or destroyed. In syphilis, alcoholism, rheumatism and other similar states the toxic element is recognized, in other insanities the causation is best arrived at from other points of view: in short that insanity is a protean disorder and no single etiological factor is sufficient to explain these.

Dr. Ford Robertson spoke of the toxic theory but added no new features to the discussion. His definition of toxemia is interesting although from a pharmacological side very indefinite and unsatisfactory: "Any chemical substance which on being brought to a cell and taken up by it, caused disorder of its metabolism, was a toxine for that cell." Melancholia he regards as essentially a toxemia. He develops a few straw bail arguments, assuming, for instance, that neurologists regarded tabes as a disease of the cord, or that insanity was a disease of the brain, etc. No thinking alienist or neurologist ever reasons thus, nor have they for many a year.

Dr. G. R. Wilson gives some sound remarks on the breadth of the subject practically bearing out Dr. Clouston's closing remarks. Dr. Yellowlees emphasized the mental influences with which every alienist is familiar but the pathologist would seem to disregard.

Dr. Bruce raised the question, "Do the mental symptoms precede the physical or the reverse?" a question which the modern physiological psycho-pathologists would, we believe, find unnecessary and non vital.

Dr. Marr writes that when actual experimental proof of the relationship can be shown then there will be time to consider the theory.

3. *Surgical Treatment of Delusional Insanity.*—Dr. T. C. Shaw, adopts the thesis that disease of the brain is never universal, but is apt to be localized and suggests an ideal for operative treatment of some of the delusional insanities on the lines of operative interference in Jacksonian epilepsy. By a careful study of the symptoms, it is important to try to find a primary lesion focus, if possible. The problem of localization was one in need of thorough investigation. He had nothing definite to offer but the paper is suggestive and timely.

4. *Sleep, Narcotics and Mental Disease.*—Dr. Henry Rayner limits his consideration of sleep to such aspects of it as are related to the question of the treatment of sleeplessness by narcotics; to consider whether the state of narcotic sleep or narcotic stupor is as reparative as normal sleep, and whether the relief of the symptom sleeplessnss by the use of narcotics may not be too dearly purchased by the harm done in other directions. He concludes from a theoretical consideration of the pharmacological action of the various hypnotics, etc., that more harm is apt to result from the use of these agents than good. His arguments really resolve themselves into a question of his own clinical

experience and this has led him gradually to discard the use of narcotics, altogether in narcotic dosage, and only at rare intervals in the hypnotic form, and then only in the form of bromide, or a small quantity of alcohol.

5. *Morphinomania.*—Dr. Robert Jones, of Claybury Asylum, London, gives a short account of eight cases of insanity resulting from the habitual use of opium or morphine. Of the forms of insanity noted, the depressed insane states were commonest. Three males were melancholy and one maniacal; two females were melancholy, one was suffering from delusional insanity and one from mania. In the matter of treatment he advocates sudden withdrawal.

6. *Evolution of Delusions and Melancholia.*—Dr. L. Weatherly says that in many melancholiacs the delusions have not had their origin in the imagination only, but they have been evolved from some definite reality. A tendency to brood over these realities becomes more and more rooted and they take full possession of the mind, overmaster the will, pervert the reason and gradually develop into a systematized delusion. To treat these cases half measures are of little value and the author advocates the following: (1) Cut the patient adrift from his associations and place in a new environment; (2) build up the physical health; (3) occupy the mind by diversified walks and amusement, neither fatiguing, nor permitting time to hang heavy; (4) gain the patient's confidence. Never deceive him; (5) never allow the attendants or nurses to attempt to get their patients to do what they wish by false promises, or by agreement with them in their insane ideas.

7. *Pupillary Symptoms in the Insane.*—Dr. T. P. Cowen practically limits his paper to the pupillary symptoms as seen in general paresis. Two classes of pupillary abnormalities are observed in insanities, he writes: (a) inconstant variations; (b) persistent or wholly progressive impairment. The former are alone met with in cases other than general paresis and senile dementia, whereas both classes of symptoms are present in the latter organic disease. In general paralysis the first eye symptom is a slight inequality of the pupils with a sluggishness on the part of the larger pupil to contract to a subdued light, accompanied by an absence of the usual dilatation following cutaneous stimulation, while all the other reactions are perfectly normal. Of the symptoms in detail he says: *Size*—The pupil is more often dilated, which dilatation may be unilateral or in both. *Inequality*—This is an early symptom and not necessarily associated with impairment of the reflexes. *Contour*—One or both may be irregular. They may be oval above, below, or in both situations. *Mobility*—He finds higher figures than those of Bevan Lewis, 13.6 per cent. *Light Reflex*—In 33 per cent. of his cases both pupils were fixed; in 38 per cent. one or other was fixed or sluggish; 23 per cent. showed sluggish reaction in both; 3 per cent. were normal; 2 per cent. showed a constant oscillation.

These affections of the pupil are not confined to true paresis but may be seen in alcoholic, syphilitic and saturnine pseudo-paresis. In the remissions of paresis the pupillary symptoms may disappear. This recovery, he notes, he has never observed with the markedly myotic pupil.

8. *Asylum Dysentery.*—Dr. Macmillan gives his experiences with this disease at Claybury. The means adopted to prevent its spread are isolation, and asepsis in regard to all the details of the patients, food, dress, etc. Especial attention should be devoted to the relapsing cases. So far as active treatment is concerned, no specific has as yet been found. In uncomplicated cases the treatment is expectant. In the more severe cases castor oil dr. ss-iss, with or without opium, or magnesium sulphate, are exhibited. The newer proteid foods, as tropan,

plasmon, etc., are of service. Alcoholic stimulation may be necessary. In the excessive diarrheas, after the disappearance of blood, subnitrate of bismuth and opium are valuable. Thirst is best relieved by cracked ice; pain is relieved by turpentine stupes, and tenesmus is remedied by small enemata of opium and starch.

9. *Psychiatric Wards at Copenhagen.*—A short account of the buildings used in the Copenhagen general hospital for psychiatric purposes. JELLIFFE.

Jahrbücher f. Psychiatrie und Neurologie.

(Vol. 21, Nos. 1 and 2, 1902.)

1. Changes in the Motor Cells of the Spinal Cord After Resection and Tearing out of the Peripheral Nerves. E. STRAUSSLER.
2. Migraine Psychosis. KRAFFT-EBING.
3. Clinical Discussion of So-Called Traumatic Syringomyelia. R. KNIEBOCK.
4. The Clinical and Anatomical Facts in a Case of Cerebellar Tumor. M. PROBST and K. von WIEG.
5. A Case of Isolated Softening of the Gyrus Hippocampus and Its Immediate Vicinity—Secondary Denegeration. E. BISCHOFF.

1. *Changes in Motor Cells of Spinal Cord.*—Although for a decade the ganglion cells have been most earnestly studied, the results cannot be said to be satisfactory. The difference of opinion has extended even to the fundamental principles which Nissl promulgated, namely, that changes in the nerve cell take place when there is a break in continuity between the nerve and the muscle cell, irrespective of how the break occurs; that is, whether the nerve is simply cut, resected, or torn out with violence. Van Gehuchten and others found that simple interruption of continuity caused no cellular changes, while De Buck and Vanderlinden were not able to demonstrate cell changes in a number of experimental amputations on the extremities of animals. Marinesco has repeatedly called attention to the fact that a difference exists accordingly as the nerve is torn, or is simply cut. With this question came also another, that of retrograde degeneration, which, first announced by Nissl, was seized upon eagerly by other investigators as an explanation of the various different findings in experiments of this nature. The author of this paper planned a series of experiments which had for their main purpose the determination of the difference in the cells of the cord which is found when a simple break in continuity of a nerve fiber exists and in one in which the break is caused by the forcible tearing out of the nerve. Cats were used for the experiment and the brachial plexus or the sciatic nerve was selected as the object of the experiment. The results after resection were the following: From five to thirty days after the operation a gradual progressive alteration of the ganglion cells was observed. This alteration was especially marked in the tigroid substance. It was accompanied by swelling of the cells, with little or no alteration of the nucleus. The cell branches were broken. After tearing out the spinal nerves, cellular changes appeared in twenty-four hours, which at first were limited to the tigroid substance. Within five days definite changes in the nucleus were added, which in many cases resulted in the destruction of the same. Thirty days after the operation the process is concluded with the destruction of more than half the cells. Tearing out of the spinal nerves causes a lesion of the anterior column, which leads to a reactive inflammation, with proliferation of the glia cells. The author ends this study with the following general conclusions: (1) The changes which follow an uncomplicated simple resection of the spinal nerves